Exhibit A

TENNCARE PARTICIPATING PHARMACY APPLICATION

For Ambulatory and Long Term Care Pharmacy Providers

Pharmacy Name_____ Pharmacy NCPDP (NABP) Number _____

Pharmacy Address _____
(location of business) (number and street)

_____
(city, state) (zip code) (county)

Pharmacy Address _____
(where remittance is sent, if different) (number and street)

_____
(city, state) (zip code) (county)

Pharmacy Telephone Number _____Fax _____
(area code) (number) (area code) (number)

Pharmacy E-mail Address _____

Pharmacy License Number_____ Pharmacy DEA Number_____

Pharmacy Federal Tax ID Number (IRS No.)_____

Pharmacy Owner Name_____

Pharmacy Owner Address_____
(number and street) (city, state) (zip code)

Has the Pharmacy Owner(s) or any other current staff or pharmacists ever been convicted of any criminal offenses against Medicaid or Medicare or ever been excluded from participation in Medicaid or Medicare as a pharmacy provider?

[ ] Yes [ ] No

If, yes, please explain the type of conviction or exclusion, the staff involved and if reinstatement has occurred.

_____

_____

_____

_____

_____

Application Surety Statement: "I certify that the information provided on this application is complete and accurate to the best of my knowledge and that the Pharmacy identified herein will comply with all of the requirements set forth in the Pharmacy Participation Agreement and the TennCare Pharmacy Manual."

Signature:_____Date:_____

Printed Name:_____Title:_____

Return this application to: **TennCare**
Attn: Pharmacy Program
Nashville, Tennessee 37247-6501 **Or fax it to: TennCare toll-free 1-888-298-4130**

For Official TennCare Use Only

Pharmacy License Verified_____
(date)

Verified by_____
(name)

Pharmacy License Status_____

OIG Sanctions **[ ]** **[ ]**
Yes **No**

Comments_____

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